Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306912100M
Compliance #: HL306917802C

Date Concluded: June 22, 2026

Name, Address, and County of Licensee Investigated:
Brookdale Eden Prairie
7513 Mitchell Road
Eden Prairie, MN 55344
Hennepin County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Brandon Martfeld, RN, BSN, Special Investigator

Finding: Not Substantiated

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The alleged perpetrators (AP #1, AP #2, and AP #3), facility staff members, abused the resident while restraining the resident during administering of medications.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. Although the actions of AP #1 and AP #3 were inappropriate the facility staff were attempting to administer the resident's pain medication. The incident did not meet the definition of abuse.

The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed staff. The investigation included review of the resident records, death record, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed residents and staff interactions at the facility.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, arthritis, and macular degeneration (an eye disease that causes vision loss). The resident's service plan included assistance with medication administration. The resident's assessment indicated the resident needed assistance from staff for activities of daily living and had severe cognitive impairment. The resident had incoherent speech, chronic pain, and was not being able to call for help or verbalize concerns.

The resident's medication administration record indicated prior to the incident the resident had a history of refusing her medications however there was not interventions or directions for the staff to follow when the resident refused her medications.

Facility documents indicated during scheduled medication administration the resident refused her medication. AP #1 attempted to administer acetaminophen and Oxycodone (medication for severe, chronic pain). The resident verbally refused the medications and turned her head away. AP #1 and AP #3 physically held the resident's head and hands while attempting to administer the resident's medications. The resident resisted while being held and the medication was placed in the resident's mouth. The resident continued to refuse and spit the medication out.

AP #1 agreed to interview and then later declined.

During an interview, AP #2 stated she was a witness to the incident. AP #1 used her palm of her hand to hold the resident's head against the back of the wheelchair. The resident's medication was in a spoon full of pudding and AP #1 inserted the medication into the resident's mouth. At the same time AP #3 held the resident's hands. AP #2 stated during the incident with AP #1 and AP #3, the resident was squirming, moving her head side to side, and spit out the medication. AP #2 stated she did not administer medications.

During an interview, AP #3 stated she held the resident's hands in way that was shaking the resident's hands. AP #3 stated the resident had a history of refusing medications. AP #3 stated she did not administer medications.

During an interview, leadership stated the resident did not speak coherent sentences, but the resident would yell out, stomp her feet, and if she did not like something, she would push it away with her hands. Also, if the resident did not like the taste of something, she would spit it out. Leadership stated AP #1 and AP #3 were administering the resident's bedtime medications.

During an interview, nursing leadership stated the resident had a history of refusing medications. During the incident, the resident's medical record lacked interventions or directions to the unlicensed staff of what to do when the resident refused medications. Following the incident, directions to staff on how to approach the resident, placing an item in the resident's hands to prevent the resident from striking staff, and education was completed with staff regarding abuse, neglect, and approach.

During an interview, a family member stated he was not concerned about the incident and that the incident was not done with malicious intent.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

“Not Substantiated” means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening; or
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: No. The resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No, AP #1 did not respond to interview requests. Yes, for AP #2 and AP #3.

Action taken by facility:
The facility conducted an internal investigation. AP #1, AP #2, and AP #3 are no longer employed at the facility. Following the incident, interventions were put in place for when the resident would refuse medications and training on abuse, neglect, and resident approach was completed for all the staff.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30691	A. BUILDING: _____ B. WING _____	C 06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EDEN PRAIRIE	7513 MITCHELL ROAD EDEN PRAIRIE, MN 55344

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments On June 2, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL306912100M / #HL306917802C. No correction orders are issued.	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	